Quest FOR Health
CHIROPRACTIC

Letter of Protection – Medical Lien

Date of Accident: _____ **Med Pay Insurance: Yes ___No _____**

Med Pay Insurance Company & Claim Number:

_____

At Fault Insurance Company & Claim Number:

_____

Patient Name: _____ Patient Signature: _____ Date:_____

Patient Address: _____ County:_____

Attorney Name: _____ Attorney Signature: _____ Date:_____

Attorney Address:_____

Attorney Phone Number: _____ Attorney Fax Number: _____

I _____ (Client/Patient) do hereby authorize Quest for Health Chiropractic to furnish you, my attorney, with a full report of his examination, diagnosis, treatment, prognosis, etc. of myself regarding the incident in which I was involved.

I hereby authorize and direct you, my attorney, to pay directly the agreed amount out of my share of any collection made on my behalf against and party liable for the injuries requiring medical treatment by Quest for Health Chiropractic.

I hereby further give a lien on my case to Quest for Health Chiropractic against any and all proceeds of any settlement, judgment or verdict which may be paid to you, my attorney, or myself as the result of the injuries for which I have been treated or injuries in connection therewith.

I hereby authorize and direct my attorney to cooperate with Quest for Health Chiropractic when/if they inquire concerning the status of any claim or suit on my/our behalf, and such advice shall be for my account and without charge or cost to Quest for Health Chiropractic.

I fully understand that I am directly and fully responsible for all medical bills submitted by Quest for Health Chiropractic for services rendered to me and, that this agreement is made solely for said medical provider's additional protection and in consideration of the awaiting payment.

I further understand that such payment is not contingent on any settlement, judgment or verdict by which I may eventually recover said fee. I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify any subsequent attorney of this lien and notify you the name, address, telephone number of my new attorney.

Should the below named attorney not agree to signing this letter of protection, Quest for Health Chiropractic may revoke this letter of protection by providing written notice to both the attorney and patient and Quest for Health Chiropractic may then actively pursue collection of the account or accounts in its normal manner.

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QUEST FOR HEALTH CHIROPRACTIC

Automobile/PI Accident or Work Comp Questionnaire

_____ _____ _____

Patient's Name **Date of Birth** **HR#:**

Dear Patient:
This information is considered confidential. Your answers will help us determine if chiropractic care can help your condition. We will not accept your case if we do not believe your condition will respond satisfactorily to care. In order for us to understand your condition properly, please be as neat and accurate as possible while completing this form.
Thank you.

Please answer all questions completely.

Please explain in detail how your accident happened: _____

_____

_____

What were the time and date of present injury? _____

Where did you feel pain immediately after the accident? _____

List the extent of your injuries as you know them: _____

_____

_____

Did you require post-accident hospitalization? ☐ Yes ☐ No

Check symptoms you have noticed since the accident:

___ Headache
___ Light Bothers Eyes
___ Head Seems to Heavy
___ Pins and Needles in Arms
___ Sleeping Problems
___ Pins and Needles in Legs
___ Numbness in Fingers
___ Numbness in Toes
___ Shortness of Breath
___ Dizziness
___ Buzzing in Ears
___ Memory Loss
___ Ears Ring
___ Back Pain
___ Constipation
___ Loss of Smell
___ Loss of Taste
___ Stomach Upset
___ Depression
___ Diarrhea
___ Feet Cold
___ Hands Cold
___ Face Flushed
___ Tension
___ Fever
___ Chest Pain
___ Fatigue
___ Neck Pain
___ Neck Stiff
___ Fainting
___ Loss of Balance
___ Nervousness
___ Irritability
___ Cold Sweats

Symptoms other than above:

_____

_____

Where were you taken after the accident? _____

Hospitalized? ☐ Yes ☐ No If yes, admitted? _____ How long? _____

Name of Hospital: _____

Name of Doctor(s): _____

Patient's Name **Date of Birth** **HR#:**

What treatment was given? _____

Was any other doctor consulted after your accident? ☐ Yes ☐ No

If so, what was the doctor's name? _____ D.C., M.D., D.O., D.D.S.

What was the diagnosis? _____

What treatment was given? _____

How often did you see the doctor? _____

How long did you see the doctor? _____

Have you ever had any complaints in the involved area before? ☐ Yes ☐ No

If so, what were the complaints? _____

Before the injury were you capable of working on an equal basis with others your age? ☐ Yes ☐ No

Are your work activities restricted as a result of this accident? ☐ Yes ☐ No

Since this injury are your symptoms ... ☐ Improving? ☐ Getting worse? ☐ Same?

Driver of other vehicle (if any):

Name _____ Insurance Company _____ Policy No. _____

Driver of vehicle in which you were injured (if applicable):

Name _____ Insurance Company _____ Policy No. _____

Name of your insurance adjustor _____

Have you retained an attorney? ☐ Yes ☐ No

If so, his/her name and address _____

You were heading North/ East/ South/ West on _____ (street or highway)

Other vehicle was heading North/ East/ South/ West on _____ (street or highway)

Were police notified? ☐ Yes ☐ No

Were you knocked unconscious? ☐ Yes ☐ No If yes, for how long? _____

You were struck from Behind/ Front/ Left Side/ Right Side _____

You were Driver/ Passenger/ Front seat/ Back Seat/ Using seat belts _____

Patient Signature _____ Date _____

Doctor Signature _____ Date _____

Quadruple Visual Analogue Scale

//Please read carefully//
Instructions: Please circle the number that best describes the question being asked.

***Note**: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.*

A. _____ **B.** _____ **C.** _____ **D.** _____

1. What is your pain **RIGHT NOW**?

No pain _____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

2. What is your **TYPICAL** or **AVERAGE** pain?

No pain _____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

3. What is your pain level **AT ITS BEST**? (How close to "0" does your pain get at its best?)

No pain _____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

4. What is your pain level **AT ITS WORST?** (How close to "10" does your pain get at its worst?)

No pain _____ **Worst possible pain**
0 1 2 3 4 5 6 7 8 9 10

Other comments: _____

_____

By signing below, you are acknowledging that you have filled out all the above accurately and to the best of your ability.

*Print Name*_____*Signature*_____*Date* _____

Goals

What are the top three goals that you would like to achieve through chiropractic care?

1._____

2._____

3._____